Client Satisfaction Survey

1. Agency Name:_____

2. Agency City: _____

3. How did you learn about these services?
   - ◻ Friend/Relative
   - ◻ Pregnancy Care Provider
   - ◻ Media (television, radio, newspaper)
   - ◻ Adoption Agency
   - ◻ School
   - ◻ Hospital
   - ◻ Brochure from agency listed above
   - ◻ Church
   - ◻ Health Department
   - ◻ Another agency: _____
   - ◻ Other, specify: _____

4. Check the services that you received as a result of your participation with the Pregnancy Maintenance Initiative/Case Management.
   - ◻ Prenatal Medical Care
   - ◻ Medical Care (non-pregnancy related)
     - ◻ Client ◻ Infant
   - ◻ Housing
   - ◻ Alternative Education
   - ◻ Paternal Involvement Support
   - ◻ Adoption Guidance
   - ◻ Drug/Alcohol Assessment/Treatment
   - ◻ Domestic Abuse Protection
   - ◻ Child Care
   - ◻ Parenting Education/Support
   - ◻ Transportation

5. How long did you wait for your first visit with the PMI case manager?
   - ◻ less than 1 week
   - ◻ 1 week
   - ◻ 2 weeks
   - ◻ 3 weeks
   - ◻ 4 weeks or more

6. Did you have problems getting to the services (e.g., transportation, appointments conflicted with work schedule or school, child care)?
   ◻ No ◻ Yes Describe the problem: _____
   _____

7. Were the days and times for services good for you?
   ◻ No ◻ Yes What days would have been better for you? _____
   _____

8. On the average, how long did you have to wait before you were seen by the case manager or other staff at this agency:
   - ◻ less than 15 minutes
   - ◻ 15-30 minutes
   - ◻ 31-45 minutes
   - ◻ 46 minutes - 1 hour
   - ◻ 1-2 hours
   - ◻ more than 2 hours
   - ◻ not applicable

9. During your visits:
   Did the case manager carefully listen to you? ◻ Yes ◻ No
   Did service providers carefully listen to you? ◻ Yes ◻ No
   Do you feel you participated in the goal planning? ◻ Yes ◻ No
   Were things explained in a way you could understand? ◻ Yes ◻ No
   If you checked "no" to any of the above, please explain: _____
   _____

10. Did you feel you were fully informed of:
    Available services to continue your pregnancy? ◻ Yes ◻ No
    Location of services? ◻ Yes ◻ No
    Requirements of services? ◻ Yes ◻ No
    Length of services during pregnancy and after? ◻ Yes ◻ No

11. If these services had been unavailable, what would you have done in relation to your pregnancy and other needs?
    _____
    _____
    _____

12. Would you recommend these services to a friend or relative? ◻ Yes ◻ No

13. How old are you?
    ◻ under 15 ◻ 15-17 ◻ 18-19 ◻ 20-24 ◻ 25-29
    ◻ 30-34 ◻ 35-39 ◻ 40-44 ◻ 45-54 ◻ 55 or older

14. What is your race?
    ◻ White ◻ Black or African American ◻ American Indian/Alaskan Native
    ◻ Asian ◻ Native Hawaiian/Pacific Islander ◻ Other

15. Do you consider yourself to be of Hispanic origin? ◻ Yes ◻ No